

Appendix 7

Montana Department of Commerce – Income & Family Certification – Part A

By signing this form, you are declaring that you have read and agree with its contents. Tenants are required to report changes in household membership such as adding or removing members and income changes such as increase, decrease, source and employment. These changes must be reported in writing within 30 days of the date of the change using the required MDOC forms provided to all participants. Please make an appointment with your caseworker to make sure all changes have been made and are correct.

Phone # _____

Email Address _____

Unit Address: _____

Occupants: (*Attach Additional Form If Needed)

1. _____

2. _____

3. _____

4. _____

5. _____

Mailing Address: _____

Mark All Changes That Apply:

☐ Household Composition ☐ Income ☐ Assets ☐ Allowance

Effective Date: _____

Part I.

Family Composition Change:

Family Member Name	Relationship to Head	Birth Date	Sex	Social Security #	Change: Circle One
1.					Add Remove
2.					Add Remove
3.					Add Remove

* Attach Additional Form if Needed.

☐ **Zero-Income:** Fill out Part-B of this Form.

Part II.

Current Income Information As of:

Type: _____

Frequency: _____

Income: _____

Source/Employer: _____

Start Date: _____ Termination Date: _____

Has this income changed? Yes No

If yes, please explain below.

Type: _____

Frequency: _____

Income: _____

Source/Employer: _____

Start Date: _____ Termination Date: _____

Has this income changed? Yes No

If yes, please explain below.

Type: _____

Frequency: _____

Income: _____

Source/Employer: _____

Start Date: _____ Termination Date: _____

Has this income changed? Yes No

If yes, please explain below?

Appendix 6

New/Additional Income/ Asset Information:

Household Member Name: _____

Income Source/Employer: _____

Source/Employer Address: _____

Source/Employer Phone Number: _____

How often paid? (monthly, biweekly, weekly, etc.) _____

Gross Income Amount: _____

* Attach Additional Form if Needed.

Child Care / Disabled Medical Allowance Information:

Household Member Name: _____

Allowance Type: _____

Source: _____

Source Address: _____

Source Phone Number: _____

Monthly Amount: _____

* Attach Additional Form if Needed.

Part III.

Applicant/Tenant(s)' Certification

Under the penalty of perjury, I/We certify that the information provided is true and complete to the best of my/our knowledge and belief. I/We understand that we can be fined up to \$10,000 or imprisoned up to five years, or lose the subsidy HUD pays and have my/our rent increased, if I/we furnish false or incomplete information.

PHA/Agent Certification

I certify that this tenant's eligibility, rent and assistance payment have been computed in accordance with HUD's regulations and administrative procedures and that all required verifications were obtained and are accurate and complete.

Print Name: Head of House-Hold

Date

Signature: Head of House-Hold

Print Name: Spouse/Co-Head

Date

Signature: Spouse/Co-Head

Print Name: Agent

Date

Signature: Agent